STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814
(916) 322-2214

February 3, 1988

ALL COUNTY LETTER NO: 88-16

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: MEDICAL REPORT - REFUGEE CASH ASSISTANCE (RCA)/
REFUGEE DEMONSTRATION PROJECT (RDP) FORM RS-40

The purpose of this letter is to provide the County Welfare Departments (CWDs) with a new recommended form, the RS-40 "Medical Report - Refugee Cash Assistance (RCA) or Refugee Demonstration Project (RDP)." The new form requires the attending physician or licensed or certified psychologist to be more specific in determining the client's length of exemption and functional limitations from work or participation in classroom training. For RCA and RDP clients, the RS-40 may be used in place of the existing AFDC CA-61, "Medical Report." However, the AFDC CA-61 will continue to be used for AFDC purposes.

The RS-40 must be presented at the intake interview or at any other time an applicant or recipient claims to have a medical problem which may affect his/her ability to work or to participate in classroom training. The client must then take the form to an attending physician or licensed or certified psychologist to have his/her health problems defined in terms of the client's capacity to function in classroom training, as well as engaging in full or part-time employment in sedentary and manual labor. In addition, the physician/psychologist can state specific working conditions that should be avoided. A physician is defined as a person authorized to practice medicine in the State of California. A licensed or certified psychologist is defined as a person trained to perform psychological analysis, therapy, or research in the State of California.

The client has 10 working days from the date of the interview with the caseworker to have the physician/psychologist complete, sign, and return the RS-40 back to the CWD. If the physician/psychologist has not returned the RS-40 to the CWD within 10 working days, it is the CWD's responsibility to follow-up with the client on the status of his/her medical verification. There is a statement on the form requesting that the physician/psychologist complete, sign, and return the RS-40 within five working days. This should allow sufficient time for the 10 working day requirement for the return of the form to be met. When an initial medical exemption expires and the client states that he/she has a continuing medical problem, the CWD must issue a new RS-40 to verify the continuing exemption.

If the RS-40 is used, a signed copy must be maintained in the client's case file. A supply of the forms will be available from the DSS Warehouse within six to eight weeks of this All-County Letter. In the meantime, reproduce the form locally using the enclosed reproducible copy.

Any questions concerning the RS-40 should be directed to Ms. Laura J. Williams, Chief, Refugee Support Management Bureau, at (916) 322-3141 or ATSS 492-3141.

ROBERT A. HOREL
Deputy Director
Welfare Program Division

Enclosure

cc: CWDA

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

DISTRIBUTION: Original Copy: Physician or Psychologist
Second Copy: CWD
Third Copy: Case File

MEDICAL REPORT —

Refugee Cash Assistance (RCA or Refugee Demonstration Project (RDP))

COUNTY USE ONLY	
APPLICANT NAME	CASE NAME
CASE NUMBER	DATE OF APPLICATION
CASE WORKER NUMBER	DISTRICT NUMBER

INSTRUCTIONS TO PHYSICIAN OR LICENSED OR CERTIFIED PSYCHOLOGIST: The **RCA/RDP** (Circle One) applicant named claims to have a problem which may affect his/her ability to work or to participate in training. When completed, this report should provide the county welfare department with an assessment of the applicant's abililty to work or to participate in training.

I. APPLICANT and COUNTY: *Please Complete This Section*

I, _____ (NAME OF APPLICANT) hereby authorize _____ (NAME OF PHYSICIAN, PSYCHOLOGIST, HOSPITAL, ETC.)

_____ (ADDRESS OF PHYSICIAN, PSYCHOLOGIST, HOSPITAL, ETC.)

to release the medical information requested by this form to the county welfare department. I also authorize the county welfare department to share this information with the Service Provider and the Central Intake Unit. This authorization is valid for one year and I may request a copy of this authorization.

SIGNATURE OF APPLICANT _____ DATE _____

PATIENT'S NAME LAST _____ FIRST _____ MIDDLE _____ CASE NUMBER _____

II. STATEMENT OF PHYSICIAN OR LICENSED OR CERTIFIED PSYCHOLOGIST

1. Medical Problem — Diagnosis and Prognosis

_____

_____

_____

(Please explain if you believe that further laboratory work or a more complete examination will be necessary before a judgment of the degree and permanence of the disability can be made.)

DATE OF LAST EXAMINATION _____ DATE OF NEXT APPOINTMENT _____ ☐ NO APPOINTMENT NECESSARY

2. Functional Limitations: *(Check all items applicable)*
   Patient is able to:
   a. Participate in classroom training ☐ full time ☐ part time ☐ not at all
   b. Perform manual labor ☐ full time ☐ part time ☐ not at all
   c. Perform sedentary labor ☐ full time ☐ part time ☐ not at all

3. Specific working conditions to be avoided _____

_____

4. ☐ This patient is Temporarily disabled, can resume work or training on: _____ (DATE MUST BE ENTERED HERE)

5. ☐ This patient is Permanently disabled. It is anticipated that patient will never be capable of participating in work or training. *(Please explain in comments)*

6. Does this person's disability prevent or substantially reduce his/her ability to care for the child(ren) in the home? If checked "YES", please explain in comments the extent to which the person's condition prevents him/her from providing care for the child(ren) in the home. ☐ YES ☐ NO

7. Does this person's disability require someone to be in the home to care for him/her? ☐ YES ☐ NO

COMMENTS

_____

_____

SIGNATURE OF PHYSICIAN OR LICENSED OR CERTIFIED PSYCHOLOGIST _____ TELEPHONE NUMBER _____ DATE _____

SPECIALTY/TITLE _____ LICENSE OR CERTIFICATION NUMBER _____

PLEASE MAIL THIS STATEMENT WITHIN 5 WORKING DAYS TO:

COUNTY STAMP